TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OrthoTexas Physicians and Surgeons

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-16-3098-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We filed this claim electronically … Per the clearing house report DOS 12/14/2015 was transmitted on 12/16/2015 and accepted by the payer on 12/29/2015. All of these dates are within the 95 day filing deadline."

Amount in Dispute: $190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor appears to be relying solely on a claim history printout to prove the initial billing was timely sent. This printout only shows something was submitted to a clearinghouse. This is not evidence of timely submission to the carrier and the Respondent did not receive any bill within 95 days of the date of service."

Response Submitted by: White/Espey, P.L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2015	Evaluation & Management, established patient (99213) Work Status Report (99080-73)	$190.00	$124.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §102.4 sets out the procedures for non-division communications.
3. 28 Texas Administrative Code §129.5 sets out the procedures for work status reports.
4. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill by a health care

provider.

5. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation.
6. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247 – A payment or denial has already been recommended for this service.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the total reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement for the deleted services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED," and 937 – "SERVICE(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE." 28 Texas Administrative Code §133.20 requires that "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided…"

   28 Texas Administrative Code §102.4(p) states:

   > For purposes of determining the date of receipt for non-commission written communications, unless the great weight of evidence indicates otherwise, the Commission shall deem the received date to be five days after the date mailed via United States Postal Service regular mail; or the date faxed or electronically transmitted.

   Review of the submitted information finds a report indicating that the medical bill was submitted to the insurance carrier on December 29, 2015. In its position statement, the insurance carrier states that this indicates a submission to a clearinghouse. 28 Texas Administrative Code §133.210(e) states:

   > It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

   The division finds that the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203(c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

For procedure code 99213 on December 14, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.970000. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.920 is 0.929200. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.822 is 0.049320. The sum of 1.948520 is multiplied by the Division conversion factor of $56.20 for a MAR of $109.51.

28 Texas Administrative Code §129.5(i) states in relevant part:

> Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15.

Therefore the reimbursement amount for procedure code 99080-73 for date of service December 14, 2015 is $15.00.

3. The total reimbursement amount for the disputed services is $124.51. The requestor paid. $0.00. A reimbursement of $124.51 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $124.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $124.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.